PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| | R MEDICARE & MEDIC | | | | | | B NO. 0938-0391 |
|-----------|---------------------|-----------------------------------|----------------------------|--------|--|------------------|-----------------|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | | COMPLETED | |
| | | 15G652 | B. WIN | | | 01/14/ | /2013 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | SEPH ST | | |
| DEVELO | PMENTAL SERVIO | CES INC | | | ISBURG, IN 47240 | | |
| (X4) ID | SUMMARY S | SUMMARY STATEMENT OF DEFICIENCIES | | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TF | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | 12 | DATE |
| W0000 | | | | | | | |
| | | | | | | | |
| | This visit was fo | or the fundamental | W0 | 000 | | | |
| | recertification a | nd state licensure survey. | | | | | |
| | | 3 | | | | | |
| | Survey dates: Ia | nuary 8, 9, 10, 11 and 14, | | | | | |
| | 2013 | muary 0, 7, 10, 11 and 14, | | | | | |
| | 2013 | | | | | | |
| | | | | | | | |
| | Facility Number | | | | | | |
| | Provider Number | er: 15G652 | | | | | |
| | AIM Number: 1 | .00233930 | | | | | |
| | | | | | | | |
| | Surveyor: Steve | en Schwing, Medical | | | | | |
| | Surveyor III | en genwing, Medicai | | | | | |
| | Surveyor III | | | | | | |
| | | | | | | | |
| | | ies also reflect state | | | | | |
| | findings in acco | rdance with 460 IAC 9. | | | | | |
| | | | | | | | |
| | Quality Review | was completed on | | | | | |
| | | Shebel, Medical Surveyor | | | | | |
| | III. | Silesei, inicalcai sai veyoi | | | | | |
| | 111. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID:

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|----------------------|------------------------------|--------------------------------|--------|--|------------|--------------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 15G652 | A. BUII B. WIN | | | 01/14/2013 | |
| | | | D. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | ES INC | | | ISBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | I | | (V5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION |
| TAG | * | LSC IDENTIFYING INFORMATION) | TAG | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΓE | DATE |
| W0126 | 483.420(a)(4) | , | | | | | |
| | | F CLIENTS RIGHTS | | | | | |
| | The facility must | ensure the rights of all | | | | | |
| | | e, the facility must allow | | | | | |
| | | to manage their financial | | | | | |
| | | them to do so to the extent | | | | | |
| | of their capabilitie | | W ₀ | 126 | | | 02/13/2013 |
| | | ation and interview for 2 | WU | 120 | W126 | | 02/13/2013 |
| | _ | d clients (#1 and #2), the | | | VV IZU | | |
| | | ensure the clients' | | | QIDP will retrain staff on | | |
| | received training | gusing real money. | | | appropriate teaching techniques and | d | |
| | | | | | the importance of using real money | | |
| | Findings include | : | when working with clients on m | | when working with clients on mone | y | |
| | | | | | goals. QIDP or designee will observe | e | |
| | An observation v | was conducted at the | | | at least weekly for one month and a | t | |
| | group home on 1 | /9/13 from 4:11 PM to | | | least monthly thereafter to ensure | | |
| | | 77 PM, staff #1 provided | | | compliance in this area. | | |
| | | #2 regarding money. | | | | | |
| | _ | | | | | | |
| | | ked to identify paper | | | Responsible for QA: QIDP | | |
| | _ | as well as coins. Staff #1 | | | Responsible for QA. QIDF | | |
| | • | s and fake paper money. | | | | | |
| | | If #1 provided training to | | | | | |
| | client #1 regarding | ng money. Client #1 was | | | | | |
| | asked to identify | different plastic coins. | | | | | |
| | | | | | | | |
| | An interview wit | th staff #3 was conducted | | | | | |
| | on 1/9/13 at 4:51 | PM. Staff #3 indicated | | | | | |
| | | plastic paper and coins for | | | | | |
| | their training. | paper and como to: | | | | | |
| | aren nummig. | | | | | | |
| | An interview we | s conducted with the | 1 | | | | |
| | | | | | | | |
| | Qualified Menta | | 1 | | | | |
| | ` ~ | MRP) on 1/10/13 at 12:00 | | | | | |
| | - | indicated the clients | | | | | |
| | should be using | real money for the | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 2 of 33

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| | of Correction identification number: 15G652 | (X2) MULTIPLE CONS A. BUILDING B. WING | 00 | COMPLETED 01/14/2013 |
|--------------------------|---|--|---|----------------------|
| | PROVIDER OR SUPPLIER PMENTAL SERVICES INC | 901 JOSE | DRESS, CITY, STATE, ZIP CODE PH ST BURG, IN 47240 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | training. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated the clients should be using real money for their training. 9-3-2(a) | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet

Page 3 of 33

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|----------------------|-------------------------------|--------|----------|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPLET | ΓED |
| | | 15G652 | B. WIN | | | 01/14/20 | 013 |
| NAME OF E | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | ES INC | | GREEN | NSBURG, IN 47240 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX | · · | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION | TE (| COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| W0149 | 483.420(d)(1) | ENT OF CLIENTS | | | | | |
| | | develop and implement | | | | | |
| | | nd procedures that prohibit | | | | | |
| | 1 | glect or abuse of the client. | | | | | |
| | | review and interview for | W0 | 149 | | | 02/13/2013 |
| | | nvestigative reports | | | W149 | | |
| | | ng client #2, the facility | | | Agency policy and procedures on | | |
| | _ | ent its policies and | | | prohibiting mistreatment, neglect, | | |
| | procedures for co | onducting an | | | or abuse of clients, reporting of | | |
| | investigation of a | an injury of unknown | | | incidents to the state, and | | |
| | origin. | | | | investigations were reviewed and | | |
| | | | | | determined appropriate. SGL | | |
| | Findings include | ¢ | | | manager will retrain QIDP's on | | |
| | | | | | conducting thorough and timely investigations per agency policy. | | |
| | A review of the f | facility's | | | SGL manager will review | | |
| | incident/investig | ative reports was | | | investigations to ensure compliance | | |
| | conducted on 1/8 | 8/13 at 1:33 PM. A | | | in this area. | | |
| | Medical Incident | t Report, dated, 10/29/12 | | | | | |
| | at 3:40 AM, indi | cated, "There was a loud | | | | | |
| | boom that came | from the bathroom. | | | Responsible for QA: SGL Manager, | | |
| | When I went to o | check [client #2] was on | | | QIDP | | |
| | her way up to the | e front. She didn't have | | | | | |
| | | o I went to get them. | | | | | |
| | There was blood | on bedroom floor. Her | | | | | |
| | blankets were als | so on floor suggesting she | | | | | |
| | | sic) out of bed. I put | | | | | |
| | , | ssure on her ear to stop | | | | | |
| | | alled the emergency | | | | | |
| | pager, [name of | | | | | | |
| | | essional Assistant], and | | | | | |
| | | t indicated client #2 had a | | | | | |
| | _ | ck, to her right ear and a | | | | | |
| | | nt forehead. The report | | | | | |
| | | np was 2 inches around. | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 4 of 33

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | |
|--|---|------------------------------|--------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 15G652 | B. WIN | G | | 01/14/ | 2013 |
| NAME OF P | PROVIDER OR SUPPLIER | | - | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | ES INC | | GREEN | SBURG, IN 47240 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CONCROSS-REFERENCED TO THE APPROPRIATE | | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | | | DATE |
| | | Developmental Disabilities | | | | | |
| | | dated 10/29/12, indicated | | | | | |
| | the incident occurred at "approximately | | | | | | |
| | | report indicated, "[Staff | | | | | |
| | | [client #2] had fallen | | | | | |
| | and struck her rig | ght side of her head and | | | | | |
| | ear on the bedsic | le table [Client #2] had | | | | | |
| | gotten tangled in | the bedcovers and tried | | | | | |
| | to get out of bed | when she fell. Injury | | | | | |
| | was a large knot | on the front right | | | | | |
| | forehead and a c | ut behind the right ear." | | | | | |
| | The facility did 1 | not provide | | | | | |
| | documentation o | of an investigation into the | | | | | |
| | | was no documentation | | | | | |
| | client #2 was int | | | | | | |
| | | | | | | | |
| | A review of the | facility's policy on | | | | | |
| | conducting inves | stigations was conducted | | | | | |
| | on 1/8/13 at 1:04 | PM. The facility's | | | | | |
| | Protocol for Con | npleting Investigations, | | | | | |
| | | licated, "Any event | | | | | |
| | | tential or actual risk of | | | | | |
| | harm to a client | | | | | | |
| | | orted, investigated and | | | | | |
| | · • | taken to alleviate the | | | | | |
| | potential for futu | | | | | | |
| | . ^ | st be initiated within 24 | | | | | |
| | _ | eted within 5 working | | | | | |
| | 1 | ey indicated, in part, | | | | | |
| | | igated immediately and | | | | | |
| | | e policy indicated, "1. | | | | | |
| | " | pected violations of | | | | | |
| | | | | | | | |
| | 1 - | neglect, or inadequate | | | | | |
| | protection of the | health and safety of | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 5 of 33

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G652 | | A. BUILDING B. WING | | | COMPLETED 01/14/2013 | | |
|---|---|------------------------------|--------|---|---|--------|------------|
| | | 100002 | B. WIN | | | 01/14/ | 2010 |
| NAME OF P | PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP CODE SEPH ST | | |
| DEVELO | PMENTAL SERVIC | ES INC | | | ISBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDE DEFICIENCY) | | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCI) | | DATE |
| | | ed will be investigated | | | | | |
| | I | thoroughly. Examples | | | | | |
| | | otection of health and | | | | | |
| | _ | at are not limited to: | | | | | |
| | _ | own origin, behavior | | | | | |
| | | ig in client/staff injuries, | | | | | |
| | | ng in the need of medical | | | | | |
| | | nts caused by possible | | | | | |
| | _ | suspected criminal | | | | | |
| | activity by staff of | | | | | | |
| | _ | st be thorough and shall | | | | | |
| | include the following: a. Review of the | | | | | | |
| | incident reports, b. Interview with the | | | | | | |
| | _ | rdian and/or advocate, c. | | | | | |
| | | staff involved including | | | | | |
| | _ | le. The policy indicated, | | | | | |
| | _ | ve report should include | | | | | |
| | _ | formation as applicable: | | | | | |
| | - | the concern, b. Review | | | | | |
| | 1 | any documentation, c. | | | | | |
| | Listing and sumr | nary of personal | | | | | |
| | interviews, d. Re | view of agency policies, | | | | | |
| | e. A summary of | findings/conclusions | | | | | |
| | investigation has | discovered, f. | | | | | |
| | Resolution/outco | ome, and g. Suggestive | | | | | |
| | Corrective Action | n to prevent further | | | | | |
| | issues from reocc | curring." | | | | | |
| | An interview was | s conducted with the | | | | | |
| | Qualified Mental | | | | | | |
| | - | MRP) on 1/10/13 at 12:00 | | | | | |
| | PM. The QMRP | | | | | | |
| | - | ould have been conducted. | | | | | |
| | | | | | | | |
| | | | 1 | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 6 of 33

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 15G652 | A. BUILDING B. WING | 00 | COMPLETED 01/14/2013 |
|--------------------------|--|--|---------------------|---|----------------------|
| | PROVIDER OR SUPPLIER | | 901 JC | ADDRESS, CITY, STATE, ZIP CODE DSEPH ST NSBURG, IN 47240 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | Administrative S at 1:36 PM. AS should have been | s conducted with staff (AS) #1 on 1/14/13 #1 indicated the incident in investigated as an injury in since it was not | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

 ${\small \textbf{If continuation sheet} \qquad \textbf{Page 7 of 33}}$

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | f ' | | | (X3) DATE S | SURVEY | |
|--|---|------------------------------|---|----------|--|------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | а вілі | LDING | 00 | COMPL | ETED |
| | | 15G652 | B. WIN | | | 01/14/ | 2013 |
| NAME OF B | DOLUDED OD CLIDDLIED | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 901 JO | SEPH ST | | |
| | PMENTAL SERVIC | ES INC | | GREEN | ISBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | TE | COMPLETION | |
| TAG W0154 | | LSC IDENTIFYING INFORMATION) | | IAG | DEFICIENCE) | | DATE |
| VVU 154 | 483.420(d)(3) STAFF TRFATMI | ENT OF CLIENTS | | | | | |
| | | have evidence that all | | | | | |
| | alleged violations | | | | | | |
| | investigated. | | | | | | |
| | | review and interview for | W0 | 154 | | | 02/13/2013 |
| | | envestigative reports | | | W154 | | |
| | | ng client #2, the facility | | | Agency policy and procedures on | | |
| | failed to conduct | an investigation of an | | | prohibiting mistreatment, neglect, | | |
| | injury of unknow | vn origin. | | | or abuse of clients, reporting of | | |
| | | | | | incidents to the state, and | | |
| | Findings include | : | | | investigations were reviewed and | | |
| | - | | | | determined appropriate. SGL | | |
| | A review of the f | facility's | | | manager will retrain QIDP's on | | |
| | | ative reports was | | | conducting thorough and timely | | |
| | _ | 3/13 at 1:33 PM. A | | | investigations per agency policy. SGL manager will review | | |
| | Medical Incident | t Report, dated 10/29/12 | | | investigations to ensure compliance | | |
| | | cated, "There was a loud | | | in this area. | | |
| | · · | from the bathroom. | | | | | |
| | | check [client #2] was on | | | | | |
| | | e front. She didn't have | | | | | |
| | | o I went to get them. | | | Responsible for QA: SGL Manager, QIDP | | |
| | | on bedroom floor. Her | | | Qibr | | |
| | | so on floor suggesting she | | | | | |
| | | sic) out of bed. I put | | | | | |
| | ` | ssure on her ear to stop | | | | | |
| | | alled the emergency | | | | | |
| | pager, [name of 0 | | | | | | |
| | 1 0 7 2 | essional Assistant, and | | | | | |
| | | t indicated client #2 had a | | | | | |
| | * | | | | | | |
| | = | ck, to her right ear and a | | | | | |
| | | nt forehead. The report | | | | | |
| | indicated the bump was 2 inches around. | | | | | | |
| | | evelopmental Disabilities | | | | | |
| | Services report, o | dated 10/29/12, indicated | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 8 of 33

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | |
|--|----------------------|--------------------------------|---|---|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED | |
| | | 15G652 | B. WING | | 01/14/2013 | |
| NAME OF P | PROVIDER OR SUPPLIER | R | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | CES INC | GREEN | NSBURG, IN 47240 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCY) | DATE | |
| | | urred at "approximately | | | | |
| | | report indicated, "[Staff | | | | |
| | #6] reported that | t [client #2] had fallen | | | | |
| | and struck her ri | ght side of her head and | | | | |
| | ear on the bedsion | de table [Client #2] had | | | | |
| | gotten tangled ir | n the bedcovers and tried | | | | |
| | to get out of bed | when she fell. Injury | | | | |
| | was a large knot | on the front right | | | | |
| | forehead and a c | cut behind the right ear." | | | | |
| | The facility did | not provide | | | | |
| | - | of an investigation into the | | | | |
| | | was no documentation | | | | |
| | client #2 was int | | | | | |
| | | | | | | |
| | An interview wa | as conducted with the | | | | |
| | Qualified Menta | | | | | |
| | | MRP) on 1/10/13 at 12:00 | | | | |
| | PM. The QMRI | | | | | |
| | - | ould have been conducted. | | | | |
| | mvesuganon sno | outa nave deen conducted. | | | | |
| | An intomicor | as aandustad with | | | | |
| | | as conducted with | | | | |
| | | Staff (AS) #1 on 1/14/13 | | | | |
| | | #1 indicated the incident | | | | |
| | | n investigated as an injury | | | | |
| | | gin since it was not | | | | |
| | observed. | | | | | |
| | | | | | | |
| | 9-3-2(a) | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | <u> </u> | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 9 of 33

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE S | SURVEY | |
|--|--|---|------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | ETED |
| | | 15G652 | B. WING | | | 01/14/ | 2013 |
| | | | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 901 JOS | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | ES INC | | | ISBURG, IN 47240 | | |
| (X4) ID | SUMMARY ST | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| | REGULATORY OR | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| PREFIX TAG W0210 | A review of clier conducted on 1/1 Client #6's currer There was no do indicating the CF the Individual Pr 10/17/12 to 10/17/14 An interview was Administrative S | DGRAM PLAN for admission, the east must perform accurate eassessments as needed expreliminary evaluation of admission. The sample (#6), the ensure her functional Assessment ted or revised annually. The sample (#6) annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. The ensure her functional Assessment ted or revised annually. | W02 | TAG | | TE . | O2/13/2013 |
| | 9-3-4(a) | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 10 of 33

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | | |
|--|---------------------|--------------------------------|---|--|---------------|--|--|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | 00 | COMPLETED | | | |
| | | 15G652 | B. WING | | 01/14/2013 | | | |
| NAME OF P | PROVIDER OR SUPPLIE | R | | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| חבוירו | DMENTAL CEDVIC | DEC INC | 901 JOSEPH ST GREENSBURG, IN 47240 | | | | | |
| | PMENTAL SERVIC | | | NODUKU, IN 47240 | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | | | |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE COMPLETION | | | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION) | TAG | DEFICIENCE) | DATE | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 11 of 33

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G652 | | A. BUILDING | OO | CON | TE SURVEY MPLETED 14/2013 | |
|--|--|---|---------------------|--|----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER | | 901 . | ET ADDRESS, CITY, STATE, ZIP COD | | |
| DEVELO | PMENTAL SERVIC | ES INC | GRE | ENSBURG, IN 47240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| W0249 | formulated a clier each client must treatment prograr interventions and number and frequachievement of the individual pro Based on observinterview for 5 or and #6) living in facility failed to the clients' program Findings included Observations we home on 1/9/13 at PM and 1/10/13 AM. 1) On 1/9/13 at received her medication inclusived her medication inclusived medication inclusived her medication pass, of her medication (0 1/9/13 at 4:2 her medication (1 | terdisciplinary team has nt's individual program plan, receive a continuous active in consisting of needed services in sufficient uency to support the ne objectives identified in gram plan. ation, record review and if 6 clients (#1, #2, #4, #5 the group home, the ensure staff implemented ram plans as written. The conducted at the group from 4:11 PM to 5:42 from 5:54 AM to 7:31 4:22 PM, client #6 dications (Propranolol for ficial Tears for dry eyes) lient #6 was not notify more than one ding her PRN (as ions, prepare for a identify the side effects | W0249 | W249 Staff will be retrained on implementation of each client individual program plans. Spe training will include but not be limited to the implementation medication training objectives during each med pass for each and following the dining plan folient #6. QIDP or designee with observe at least weekly for on month then monthly thereafte ensure compliance in these are Responsible for QA: QIDP | cific confident for fill e | 02/13/2013 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY | |
|--|--|--|------------|------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 15G652 | B. WIN | IG | | 01/14/ | 2013 |
| NAME OF F | PROVIDER OR SUPPLIEF | · ? | - | | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | CES INC | | GREEN | ISBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | · · · · · · · · · · · · · · · · · · · | | TAG | Dia teliate i j | | DATE |
| | | identify the illness PRN | | | | | |
| | medications were used for and identify | | | | | | |
| | her medication. | | | | | | |
| | On 1/0/12 of 4.4 | 8 PM, client #4 received | | | | | |
| | | Thuprofen for a headache) | | | | | |
| | 1 | Client #4 was not asked to | | | | | |
| | | nen take her medication | | | | | |
| | and identify her | | | | | | |
| | and identity fiel | medication. | | | | | |
| | On 1/9/13 at 5:0 | 6 PM, client #5 received | | | | | |
| | | (Meclizine for dizziness | | | | | |
| | | Meloxicam for arthritis) | | | | | |
| | from staff #3. C | · · · · · · · · · · · · · · · · · · · | | | | | |
| | | ord her medication | | | | | |
| | | aily, self-medicate with | | | | | |
| | | and learn the names of | | | | | |
| | her medications | | | | | | |
| | ner medications | | | | | | |
| | On 1/9/13 at 5:0 | 9 PM, client #1 received | | | | | |
| | | Calgest antacid for | | | | | |
| | | l Vitamin D-3 as a | | | | | |
| | - | m staff #3. Client #1 was | | | | | |
| | | continue reviewing her | | | | | |
| | | learn the purpose of each | | | | | |
| | house PRN med | | | | | | |
| | | | | | | | |
| | On 1/9/13 at 5:1 | 1 PM, client #2 received | | | | | |
| | | Calcium with Vitamin D | | | | | |
| | · ` |) from staff #3. Client #2 | | | | | |
| | | ed to identify the illness | | | | | |
| | | ns were used for and | | | | | |
| | identify her med | | | | | | |
| | | | | | | | |
| | | | | | | | |

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Event ID: YVZN11

Facility ID: 001190

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| i i | | | (X2) MU | JLTIPLE CO | NSTRUCTION | (X3) DATE S | |
|-----------|----------------------|------------------------------|---------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUIL | DING | 00 | COMPL | |
| | | 15G652 | B. WING | 3 | | 01/14/ | 2013 |
| NAME OF E | PROVIDER OR SUPPLIER | | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | ROVIDER OR SUFFLIER | | | 901 JOS | SEPH ST | | |
| | PMENTAL SERVIC | | | | ISBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | 1 | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | 58 AM, client #2 | | | | | |
| | | dications (Genteal for | | | | | |
| | | Calcium with vitamin D | | | | | |
| | as a supplement, | Glipizide for | | | | | |
| | hypoglycemia, L | isinopril for | | | | | |
| | hypoglycemia, N | Vamenda for dementia, | | | | | |
| | Ketotifen eye dr | ops for ocular irritation) | | | | | |
| | from staff #1. C | lient #2 was not | | | | | |
| | prompted to ider | ntify the illness PRN | | | | | |
| | medications wer | e used for and identify | | | | | |
| | her medication. | , | | | | | |
| | | | | | | | |
| | On 1/10/13 at 6: | 40 AM, client #6 | | | | | |
| | | dications (Calcium with | | | | | |
| | | upplement, Escitalopram | | | | | |
| | | • • | | | | | |
| | | butynin for incontinence, | | | | | |
| | _ | remors, Artificial Tears | | | | | |
| | | Patanol for allergic | | | | | |
| | " | om staff #1. Client #6 | | | | | |
| | | d to identify more than | | | | | |
| | one medication i | ncluding her PRN | | | | | |
| | medications, pre | pare for a medication | | | | | |
| | pass, identify the | e side effects of her | | | | | |
| | medications. | | | | | | |
| | | | | | | | |
| | A review of clien | nt #1's record was | | | | | |
| | conducted on 1/1 | 10/13 at 11:52 AM. | | | | | |
| | Client #1's Indiv | idual Program Plan (IPP), | | | | | |
| | | 1/10/13, indicated she had | | | | | |
| | | ing objectives to continue | | | | | |
| | | edications and learn the | | | | | |
| | | house PRN medication. | | | | | |
| | purpose or each | nouse i Kin inculcation. | | | | | |
| | A review of clien | nt #2's record was | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 14 of 33

| | | | (X2) M | ULTIPLE CO | NSTRUCTION | (X3) DATE S | |
|-----------|----------------------|------------------------------|--------|------------|---|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUI | LDING | 00 | COMPL | |
| | | 15G652 | B. WIN | G | | 01/14/ | 2013 |
| NAME OF P | PROVIDER OR SUPPLIER | | | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | SES INC | | GREEN | SBURG, IN 47240 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| | | 10/13 at 11:48 AM. | | | | | |
| | Client #2's IPP, | dated 3/12 - 3/13, | | | | | |
| | indicated she had | | | | | | |
| | administration tr | aining objectives to | | | | | |
| | prepare for her n | nedication pass, identify | | | | | |
| | the illness PRNs | were used for, and | | | | | |
| | identify all her a | dministered medications. | | | | | |
| | | | | | | | |
| | A review of clien | nt #4's record was | | | | | |
| | conducted on 1/1 | 10/13 at 10:53 AM. | | | | | |
| | Client #4's IPP, | dated 8/3/12 - 8/3/13, | | | | | |
| | indicated she had | d a medication training | | | | | |
| | objective to prep | are and then take her | | | | | |
| | medications and | identify her medications. | | | | | |
| | | | | | | | |
| | A review of clien | nt #5's record was | | | | | |
| | conducted on 1/1 | 10/13 at 11:56 AM. | | | | | |
| | Client #5's IPP, | dated 5/2/12 - 5/2/13, | | | | | |
| | indicated she had | d a medication training | | | | | |
| | | rd her medication | | | | | |
| | _ | aily, self-medicate with | | | | | |
| | | and learn the names of | | | | | |
| | her medications. | | | | | | |
| | | | | | | | |
| | A review of clien | nt #6's record was | | | | | |
| | | 10/13 at 10:17 AM. | | | | | |
| | Client #6's IPP, | | | | | | |
| | 1 | ted she had a medication | | | | | |
| | | e to identify more than | | | | | |
| | | ncluding her PRN | | | | | |
| | | | | | | | |
| | _ | pare for a medication | | | | | |
| | * ' | e side effects of her | | | | | |
| | medications. | | | | | | |
| | | | | | | | |

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Event ID: YVZN11

Facility ID: 001190

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PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 15G652 | A. BUILDING B. WING | | | COMPLETED 01/14/2013 | |
|--------------------------|--|--|----------------------|---------------------|---|----------------------|----------------------------|
| NAME OF F | PROVIDER OR SUPPLIER | | P | STREET A | ADDRESS, CITY, STATE, ZIP CODE SEPH ST | | |
| DEVELO | PMENTAL SERVIC | ES INC | | GREEN | ISBURG, IN 47240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE |
| | Qualified Mental Professional (QM PM. The QMRP medication traini | MRP) on 1/10/13 at 12:00 indicated the clients' ng objectives should be each medication pass. | | | | | |
| | Administrative S at 1:36 PM. AS medication traini | taff (AS) #1 on 1/14/13 | | | | | |
| | dinner at 5:39 PM observed to hold to prevent her from On 1/10/13 from client #6 was not in her right hand stuffing her mout #6 ate her toast w | m 5:12 PM to the end of M, client #6 was not a prop in her right hand om stuffing her mouth. 6:15 AM to 6:39 AM, observed to hold a prop to prevent her from th. At 6:33 AM, client with no prompts to slow took bite after bite with staff. | | | | | |
| | Client #6's Dinin indicated she nee prompts to slow take smaller bites needed adaptatio such as a prop in | of the theorem of the triangle of tria | | | | | |

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Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 16 of 33

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | IDENTIFICATION NUMBER: 15G652 | A. BUII B. WIN | LDING | 00 | COMPL: 01/14/ | ETED |
|--------------------------|---|--|-------------------|---------------------|---|------------------|----------------------------|
| NAME OF F | PROVIDER OR SUPPLIER | | B. WIN | STREET A | DDDRESS, CITY, STATE, ZIP CODE | | |
| DEVELO | PMENTAL SERVIC | ES INC | | | SBURG, IN 47240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | 'E | (X5) COMPLETION DATE |
| | remind [client #6 eating. [Client # right hand to predict the street of | ARP) on 1/10/13 at 12:19 indicated client #6's ld be implemented at s conducted with taff (AS) #1 on 1/14/13 #1 indicated client #6's ld be implemented at | | | | | |

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Event ID: YVZN11

Facility ID: 001190

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G652 | | A. BUII | LDING | ONSTRUCTION 00 | (X3) DATE COMPL 01/14 / | ETED | |
|--|--|--|--------|---------------------|--|------|----------------------------|
| | PROVIDER OR SUPPLIER | | B. WIN | STREET A | ADDRESS, CITY, STATE, ZIP CODE SEPH ST ISBURG, IN 47240 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | .ΤΕ | (X5) COMPLETION DATE |
| W0262 | The committee sh monitor individual manage inapprop programs that, in committee, involvand rights. Based on record 1 of 3 clients in the specially constituted failed to review, client #6's Behave with restrictions. Findings include A review of client conducted on 1/1 Client #6's BSP, the use of two psecure (Lexapro and Producted on 1/1 Client #6's BSP, the use of two psecure that the secure of the secure that the secure was a conducted on 1/1 Client #6's BSP, the use of two psecure that the secure that the secure was a conducted on 1/1 Client #6's BSP, the use of two psecure that the secure that t | at #6's record was .0/13 at 10:17 AM. dated 10/17/12, included sychotropic medications operanolol). There was no a client #6's record the approved and monitored SP. s conducted with the I Retardation MRP) on 1/10/13 at 12:00 indicated prior to ge BSP, the HRC should | WO | 262 | HRC review and consent for client #6's BSP will be obtained. QIDP's will be retrained on agency policy and state requirements for HRC approval for any restrictive behavior plan. QIDP will obtain at least annually and as needed HRC approval on every BSP involving restrictions. QIDP will review each BSP at least annually and as needed to ensure HRC approval is obtained as needed. Responsible for QA: QIDP | ı | 02/13/2013 |

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Facility ID: 001190

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PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| | | IDENTIFICATION NUMBER: 15G652 | A. BUILDING B. WING | 00 | COMPLETED 01/14/2013 | | | | |
|--------------------------|----------------------|---|--|--|----------------------|--|--|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | | | |
| | at 1:36 PM. AS | #1 indicated the HRC approve the plan prior | | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE DATE | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

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Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 19 of 33

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE S | |
|--|--|---|---------|------------|---|-------------|------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | LDING | 00 | COMPL | ETED |
| | | 15G652 | B. WIN | | | 01/14/ | 2013 |
| VIII CE OF D | | | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P. | PROVIDER OR SUPPLIER | | | 901 JOS | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | ES INC | | | ISBURG, IN 47240 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , The state of the | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| W0317 | | ontrol of inappropriate | | | | | |
| | | gradually withdrawn at | | | | | |
| | 1 | a carefully monitored ed in conjunction with the | | | | | |
| | | eam, unless clinical | | | | | |
| | | that this is contraindicated. | | | | | |
| | i - | review and interview for | W0 | 317 | | | 02/13/2013 |
| | | | | | W317 | | |
| | | - ' ' | | | | | |
| | | • | | | QIDP will review client #3's BSP and | | |
| | | F 5, 6, 6, 6, 6, 6, 6, 6, 6, 6, 6, 6, 6, 6, | | | | | |
| | was attainable. | | | | | | |
| | Findings include | | | | i ' | 2 | |
| | i mamgs merade | • | | | | | |
| | A ravious of alice | at #2's record was | | | least annually and as needed to | | |
| | | | | | ensure compliance in this area. | | |
| | | | | | | | |
| | | * * | | | | | |
| | • | | | | | | |
| | , | * | | | Responsibility for QA: QIDP | | |
| | | | | | | | |
| | | · · | | | | | |
| | with psychiatric, | guardian review and | | | | | |
| | consultation per | below criteria: 0 | | | | | |
| | instances each m | onth of signs/symptoms | | | | | |
| | of depression for | six months." | | | | | |
| | | | | | | | |
| | An interview wa | s conducted with the | | | | | |
| | Qualified Menta | l Retardation | | | | | |
| | Professional (QN | MRP) on 1/10/13 at 12:00 | | | | | |
| | | | | | | | |
| | · · · · · · · · · · · · · · · · · · · | | | | | | |
| | . ^ | - | | | | | |
| | · ` | • | | | | | |
| | 131 Todaomig one | o pojenouopie | | | | | |
| | Based on record 1 of 3 clients in the facility failed to reduction for her was attainable. Findings include A review of client conducted on 1/10 Client #3's Behate 3/12/12, indicated medication (Celebrated Celebrated C | review and interview for the sample (#3), the ensure client #3's plan of psychotropic medication at #3's record was 10/13 at 11:14 AM. wior Support Plan, dated at she had a psychotropic exa). The plan for indicated, "Medication esought in conjunction guardian review and below criteria: 0 nonth of signs/symptoms as x six months." | WO | 317 | QIDP will review client #3's BSP and revise the criteria for medication reduction to ensure it is attainable. The revised plan will be submitted for approval by the guardian and the HRC. QIDP will review each BSP at least annually and as needed to | | 02/13/20 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 20 of 33

PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| | OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | NSTRUCTION 00 | (X3) DATE : COMPL | |
|---------------|---------------------|--|--------|---------------|---|----------------------|--------------------|
| | | 15G652 | | LDING | | 01/14/ | |
| | | | B. WIN | | ADDRESS, CITY, STATE, ZIP CODE | L | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | ES INC | | GREEN | SBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | · · | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| TAG | | ed to be revised in order | | IAG | BELLEUI.VO.1) | | DATE |
| | | ection more attainable. | | | | | |
| | to make the read | etion more attainable. | | | | | |
| | An interview wa | s conducted with | | | | | |
| | Administrative S | Staff (AS) #1 on 1/14/13 | | | | | |
| | | #1 indicated zero | | | | | |
| | | nonth for six consecutive | | | | | |
| | | attainable. AS #1 | | | | | |
| | _ | n needed to be revised to on more attainable. | | | | | |
| | make me reducti | on more attainable. | | | | | |
| | 9-3-5(a) | | | | | | |
| | <i>y</i> = 0 (a.) | | | | | | |
| | | | | | | | |
| | | | | | | | |
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 21 of 33

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) M | ULTIPLE CC | ONSTRUCTION | (X3) DATE S | SURVEY |
|--|---|---|--------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A BUI | LDING | 00 | COMPL | ETED |
| | | 15G652 | B. WIN | | | 01/14/ | 2013 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF F | PROVIDER OR SUPPLIER | t. | | 901 JO | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | CES INC | | GREEN | ISBURG, IN 47240 | | |
| (X4) ID | SUMMARY S | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | | DATE |
| W0323 | 483.460(a)(3)(i) PHYSICIAN SER | RVICES | | | | | |
| | | provide or obtain annual | | | | | |
| | | tions of each client that at a s an evaluation of vision | | | | | |
| | | review and interview for | W0 | 323 | | | 02/13/2013 |
| | | the sample (#6), the | | - | W323 | | |
| | | ensure client #6's hearing | | | | | |
| | was evaluated. | ondare eneme no s nearing | | | QIDP's have been retrained on | | |
| | was evaluated. | | | | requirements for timely annual | | |
| | Findings include | :: | | | medical exams to include hearing and vision for each client. Client #6 will be scheduled for hearing eval. | | |
| | A raviant of alia | nt #6's record was | | | QIDP and agency nurse will review | | |
| | | 10/13 at 11:14 AM. | | | each client's chart at least monthly | | |
| | | | | | to ensure all medical exams are | | |
| | | d did not contain | | | obtained timely. | | |
| | | ndicating her hearing had | | | | | |
| | | Her 5/24/12 annual | | | | | |
| | | include an assessment of | | | Deep anaible for OA. OIDD | | |
| | her hearing. | | | | Responsible for QA: QIDP | | |
| | Qualified Menta Professional (QM PM. The QMRI | MRP) on 1/10/13 at 12:00 P indicated client #6's have been evaluated | | | | | |
| | Administrative S at 1:36 PM. AS | s conducted with Staff (AS) #1 on 1/14/13 #1 indicated client #6's be evaluated annually. | | | | | |

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Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 22 of 33

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | (X2) MU | JLTIPLE CO | ONSTRUCTION | (X3) DATE S | SURVEY |
|--|----------------------|-------------------------------|---------|------------|--|-------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUII | DING | 00 | COMPL | ETED |
| | | 15G652 | B. WIN | | | 01/14/2013 | |
| | | | B. WIIV | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | SEPH ST | | |
| DEVELO | PMENTAL SERVIC | ES INC | | | ISBURG, IN 47240 | | |
| (X4) ID | STIMMADVS | TATEMENT OF DEFICIENCIES | | ID | | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | ` | LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | ΓE | DATE |
| W0356 | 483.460(g)(2) | | | 1110 | | | 5.112 |
| ******* | | VE DENTAL TREATMENT | | | | | |
| | | ensure comprehensive | | | | | |
| | - | services that include dental | | | | | |
| | care needed for re | elief of pain and infections, | | | | | |
| | | th, and maintenance of | | | | | |
| | dental health. | | | | | | 0.00 |
| | | review and interview for | W03 | 356 | | | 02/13/2013 |
| | 1 of 3 clients in t | the sample (#6), the | | | W356 | | |
| | facility failed to | ensure a follow-up dental | | | OIDD's will be not as in a disco | | |
| | appointment was | s held as scheduled and | | | QIDP's will be retrained on requirements for timely medical and | ı | |
| | recommended. | | | | dental care for each client. Client #6 | | |
| | | | | | will receive routine dental treatmen | | |
| | Findings include | | | | as recommended by her dentist. | | |
| | 1 mamgs merade | • | | | This documentation will be obtained | i | |
| | A | 4 // (1 | | | and filed appropriately. QIDP and | | |
| | | nt #6's record was | | | her assistant will review each client' | S | |
| | | 10/13 at 10:17 AM. | | | record to ensure all medical/dental | | |
| | Client #6's most | | | | evals are timely. | | |
| | appointment, dat | ted 4/25/12, indicated a | | | | | |
| | follow-up appoir | ntment was scheduled for | | | | | |
| | 10/31/12. The ap | ppointment form | | | | | |
| | indicated, "Atten | npting to hold onto teeth | | | Responsible for QA: QIDP | | |
| | · · | le but will eventually | | | | | |
| | | exts (extractions)." | | | | | |
| | | cumentation a follow-up | | | | | |
| | | cumentation a follow-up | | | | | |
| | was held. | | | | | | |
| | | 1 1 | | | | | |
| | | s conducted with the | | | | | |
| | Qualified Mental | | | | | | |
| | Professional (QN | MRP) on 1/10/13 at 12:06 | | | | | |
| | PM. The QMRP | indicated client #6's | | | | | |
| | guardian took the | e responsibility of taking | | | | | |
| | - | ppointments. The | | | | | |
| | QMRP indicated | | | | | | |
| | ` | s scheduled for April | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

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PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| | of correction identification number: 15G652 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | | | | | |
|--------------------------|--|---|--|-----------|----------------------------|--|--|--|
| | PROVIDER OR SUPPLIER PMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | | |
| | An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated client #6 should have a follow-up as scheduled and recommended by the dentist. 9-3-6(a) | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|---|------------------------|--------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 COMPLET | | | ETED | |
| | | 15G652 | B. WIN | | | 01/14/ | 2013 |
| | | | | | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | SEPH ST | | |
| | PMENTAL SERVIC | ES INC | | GREEN | ISBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ΓE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | + | TAG | DEFICIENCE | | DATE |
| W0362 | 483.460(j)(1) DRUG REGIMEN A pharmacist with interdisciplinary to regimen of each of Based on record 1 of 3 clients in the facility failed to regimen was review pharmacist. Findings included A review of client conducted on 1/10 pharmacist review regimen on 7/5/10. There was no do record indicating the drug regimen. An interview was Qualified Mental Professional (QN PM. The QMRF review should be an interview was Administrative Stat 1:36 PM. AS | I REVIEW In input from the learn must review the drug client at least quarterly. The review and interview for the sample (#6), the lensure client #6's drug liewed quarterly by the In the sample (#6), the lensure client #6's drug liewed quarterly by the In the sample (#6), the lensure client #6's drug liewed quarterly liewed quarterly liewed liemed | Wo | | Pharmacy audits were performed or 1/25/2012 and 4/26/2012. This documentation had been inadvertently purged from the house book. Staff will be retrained regarding appropriate timeframes for purging. QIDP's are given a copy of the pharmacy audits and will conduct random audits of client records quarterly to ensure documentation is in place. Responsible for QA: QIDP | | 02/13/2013 |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

If continuation sheet Page 25 of 33

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---------------------|--|--------------------|---------------|--|-----------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | | COMPLETED | |
| | | 15G652 | B. WING 01/14/2013 | | | 2013 | |
| VALUE OF DE OVERER OF GUIDA IN | | | _ | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 901 JO | SEPH ST | | |
| | PMENTAL SERVIC | | | | ISBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | · · | CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TΕ | COMPLETION DATE |
| W0448 | 483.470(i)(2)(iv) | LSC IDENTIF FING INFORMATION) | | IAU | BELIEBRET | | DATE |
| VVO-1-10 | EVACUATION DE | RILLS | | | | | |
| | | nvestigate all problems | | | | | |
| | | rills, including accidents. | | | | | |
| | | review and interview for | W0 | 448 | | | 02/13/2013 |
| | | ing in the group home | | | W448 | | |
| | • | \$5 and \$\#6\), the facility | | | Evacuation procedures and | | |
| | failed to ensure i | ssues noted during | | | documentation forms were | | |
| | evacuation drills | were investigated. | | | reviewed. Forms have been revised | | |
| | | | | | to include direction to staff to repor | t | |
| | Findings include | : | | | to QIDP anytime a client evacuation | | |
| | | | | | takes longer than 2 minutes. QIDP | | |
| | A review of the f | facility's evacuation drills | | | will retrain staff on procedures for | | |
| | was conducted or | n 1/10/13 at 9:45 AM. | | | conducting evacuation drills and proper documentation of each drill | | |
| | There was no do | cumentation an | | | to include notification to QIDP of | | |
| | investigation was | s conducted for the | | | problems occurring with any client | | |
| | _ | This affected clients #1, | | | during the drill. QIDP's will be | | |
| | #2, #3, #4, #5 an | | | | retrained on investigating any | | |
| | | : 11:00 PM, a fire drill | | | problems noted during evacuation | | |
| | took 5 minutes to | · | | | drills. QIDP reviews evacuation drill | S | |
| | | no time documented), the | | | monthly and forwards copies of | | |
| | ` | ninutes to complete. | | | these to SGL Manager for review to ensure compliance in this area. | | |
| | | time documented), the | | | ensure compilance in this area. | | |
| | ` | ninutes to complete. | | | | | |
| | | time documented), the | | | | | |
| | ` | ninutes to complete. | | | Responsible for QA: QIDP, SGL | | |
| | | 6:00 PM, the fire drill | | | Manager | | |
| | took 5 minutes to | | | | | | |
| | | at 12:30 AM, the fire drill | | | | | |
| | took 5 minutes to | · | | | | | |
| | | at 9:00 AM, the fire drill | | | | | |
| | took 4 minutes to | | | | | | |
| | | • | | | | | |
| | | at 5:00 PM, the fire drill | | | | | |
| | took 5 minutes to | o complete. | | | | | |
| | | | ı | | I | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YVZN11

Facility ID: 001190

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PRINTED: 02/07/2013 FORM APPROVED OMB NO. 0938-0391

| | of Correction identification number: 15G652 | A. BUILDING B. WING | 00 | (X3) DATE COMPI 01/14 | LETED |
|--------------------------|---|----------------------|---|-----------------------------|----------------------------|
| | PROVIDER OR SUPPLIER PMENTAL SERVICES INC | 901 JO | ADDRESS, CITY, STATE, ZIP CODE SEPH ST ISBURG, IN 47240 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY) | BE | (X5) COMPLETION DATE |
| | An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:00 PM. The QMRP indicated the targeted time for completing fire drills was under 2 minutes. The QMRP indicated the drills taking longer than 2 minutes should have been investigated. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated issues noted during evacuation drills should be investigated. AS #1 indicated the targeted time for completing drills was 1-2 minutes. 9-3-7(a) | | | | |

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Event ID: YVZN11

Facility ID: 001190

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | (X3) DATE S | SURVEY | |
|--|-------------------------------|------------------------------|--------------------|---|--|-----------|-------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | | COMPLETED | |
| | | 15G652 | B. WING 01/14/2013 | | | | |
| NAME OF D | PROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 901 JO | SEPH ST | | |
| | PMENTAL SERVIC | | | | ISBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | ID | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | ATE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE) | | DATE |
| W0463 | 483.480(a)(4) FOOD AND NUT | RITION SERVICES | | | | | |
| | The client's interd | lisciplinary team, including | | | | | |
| | | n and physician must | | | | | |
| | | ified and special diets. | | 4.60 | | | 00/10/10/10 |
| | | ation, record review and | W0 | 463 | | | 02/13/2013 |
| | | f 3 clients in the sample | | | W463 | | |
| | | failed to ensure client | | | Dietician was contacted and has | | |
| | #6's diet was rev | iewed periodically. | | | conducted an assessment for each | | |
| | | | | | client in this home. QIDP has been | | |
| | Findings include | : | | | retrained on requirement for | | |
| | | | | | periodic, at least annual, review by | | |
| | On 1/9/13 from 5 | 5:12 PM to the end of | | | dietician. QIDP will audit client's file | | |
| | dinner at 5:39 PM | M, client #6 was not | | at time of annual to ensure dietician review is current and update dining plan as needed. | | | |
| | observed to hold | a prop in her right hand | | | | | |
| | to prevent her fro | om stuffing her mouth. | | | plan as needed. | | |
| | On 1/10/13 from | 6:15 AM to 6:39 AM, | | | | | |
| | client #6 was not | t observed to hold a prop | | | | | |
| | in her right hand | to prevent her from | | Responsible for QA: QIDP | | | |
| | stuffing her mou | th. At 6:33 AM, client | | | | | |
| | _ | with no prompts to slow | | | | | |
| | down. Client #6 | took bite after bite with | | | | | |
| | no prompts from | staff. | | | | | |
| | • • | | | | | | |
| | A review of clien | nt #6's record was | | | | | |
| | conducted on 1/1 | 10/13 at 10:17 AM. | | | | | |
| | Client #6's Dinin | ng Plan, dated 3/1/12, | | | | | |
| | | eded verbal and physical | | | | | |
| | | down while eating and to | | | | | |
| | | s. The plan indicated she | | | | | |
| | | ons to prevent choking | | | | | |
| | • | her right hand. The plan | | | | | |
| | | al and physical prompts | | | | | |
| | · · | d during the meal to | | | | | |
| | | [6] to slow down while | | | | | |
| | | - | 1 | | | | |

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| | NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G652 | (X2) MULTIPLE CO A. BUILDING B. WING | 00 | COM | TE SURVEY MPLETED 14/2013 | | | |
|--------------------------|--|--|--|----------|----------------------------|--|--|--|
| | NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | | | |
| | eating. [Client #6] should use prop in right hand to prevent stuffing mouth." Client #6's most recent dietary review by the dietician was dated 4/11/11. | | | | | | | |
| | An interview was conducted with the Qualified Mental Retardation Professional (QMRP) on 1/10/13 at 12:19 PM. The QMRP indicated she was unable to locate client #6's current dietary review. On 1/10/13 at 3:24 PM, the QMRP indicated the dietician had been to the home and conducted the dietary review. The QMRP indicated the dietician failed to conduct a review in 2012. An interview was conducted with Administrative Staff (AS) #1 on 1/14/13 at 1:36 PM. AS #1 indicated the dietician should conduct annual reviews. AS #1 indicated client #6 had mealtime issues noted in her Dining Plan. 9-3-8(a) | | | | | | | |

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Event ID: YVZN11

Facility ID: 001190

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---------------------------------|---|--------------------|-------------------------------------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING 00 | | | COMPLETED | |
| | | 15G652 | B. WING 01/14/2013 | | | 2013 | |
| NAME OF D | PROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP CODE | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 901 JO | SEPH ST | | |
| | PMENTAL SERVIC | | | GREEN | ISBURG, IN 47240 | | |
| (X4) ID | | TATEMENT OF DEFICIENCIES | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCE) | | DATE |
| W0488 | 483.480(d)(4) DINING AREAS A | AND SERVICE | | | | | |
| | | assure that each client eats | | | | | |
| | _ | istent with his or her | | | | | |
| | developmental le | vel. | | | | | |
| | Based on observ | ation and interview for 6 | W0 | 488 | | | 02/13/2013 |
| | of 6 clients living | g in the group home (#1, | | | W488 | | |
| | #2, #3, #4, #5 an | d #6), the facility failed | | | QIDP will retrain staff in how to | | |
| | to ensure the clie | ents served themselves, | | | support each client in the mea preparation and clean up, and | | |
| | poured their own | drinks and cleaned up | | | dining that is consistent with their | | |
| | after breakfast. | • | | skill level and as identified in th | | | |
| | | | | | IPP's especially at breakfast. | | |
| | Findings include | | | | QIDP or designee will observe breakfast routine at least weekly for one month to ensure | | |
| | 1 mamgs morado | • | | | | | |
| | An observation v | was conducted at the | | | compliance in this area. Rand | lom | |
| | | 1/10/13 from 5:54 AM to | | | observations will continue at le | | |
| | | 05 AM, staff #1 poured | | | monthly. | | |
| | | • | | | Responsible for QA: QIDP | | |
| | | te cups sitting on the | | | | | |
| | | he coffee maker. At 6:10 | | | | | |
| | · · | ted to client #4, "I'm | | | | | |
| | | r tea going." Client #4 | | | | | |
| | | d to assist with making | | | | | |
| | | AM, staff #1 poured | | | | | |
| | | coffee into client #1, #2 and #6's coffee | | | | | |
| | • | M, staff #1 microwaved | | | | | |
| | and took the oatr | meal to the table for client | | | | | |
| | #3. Staff #1 pou | red client #4's milk. | | | | | |
| | Staff #1 poured of | client #3's milk into her | | | | | |
| | oatmeal. At 6:23 | 3 AM, staff #1 poured | | | | | |
| | clients #2, #3, #4 | 4 and #6's apple juice. | | | | | |
| | Staff #1 put clier | nt #3's toast in the toaster. | | | | | |
| | • | ff #1 put client #5's | | | | | |
| | | ning room table. Staff #5 | | | | | |
| | | empty bowl to the sink. | | | | | |
| | | ent #6's plate and cups to | | | | | |
| | Sum in took cill | one ii o s piace and cups to | | | | | |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | MBER: | e) MULTIPLE CON | NSTRUCTION 00 | (X3) DATE SURVEY COMPLETED |
|---|--|---|------------------|---|-----------------------------|
| | 15G652 | A. I | BUILDING WING | | 01/14/2013 |
| NAME OF P | ROVIDER OR SUPPLIER | . | | DDRESS, CITY, STATE, ZIP CODE | |
| | | | | SEPH ST | |
| | PMENTAL SERVICES INC | | | SBURG, IN 47240 | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | (X5) COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INI | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | DATE |
| | the sink. | | | | |
| | An interview was conducted with Qualified Mental Retardation Professional (QMRP) on 1/10/13 PM. The QMRP indicated the cli should serve and clean up after themselves. An interview was conducted with Administrative Staff (AS) #1 on 1 at 1:36 PM. AS #1 indicated the should participate to their abilities indicated the clients at this group were capable of serving themselv doing the clean up. 9-3-8(a) | at 12:00 ients 1/14/13 clients s. AS #1 home | | | |
| | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M A. BUII | | onstruction 00 | (X3) DATE : COMPL | | |
|--|---|--|--------|---------------------|--|--------|----------------------------|
| | | 15G652 | B. WIN | | | 01/14/ | 2013 |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | 901 JOS | ADDRESS, CITY, STATE, ZIP CODE SEPH ST ISBURG, IN 47240 | | |
| (X4) ID PREFIX TAG W9999 | (EACH DEFICIENC | CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE |
| | Facilities for Pers | ommunity Residential sons with Developmental | W9 | 999 | W9999 Staff files were audited and all Mantoux screenings are current at | | 02/13/2013 |
| | Disabilities Rule 1) 460 IAC 9-3- | was not met: 3 Facility Staffing | | | this time. | | |
| | duties and annua residential staff p written evidence PPD) tuberculosi was completed. Mantoux shall be of induration wit read, and by who skin test result is | ning residential job Illy thereafter, each person shall submit that a Mantoux (5TU, as skin test or chest x-ray The result of the e recorded in millimeter the the date given, date om administered. If the a significant (ten (10) ore), then a chest film | | | | | |
| | shall be done wit laboratory exami complete a diagn treatment shall be | h other physical and nations as necessary to osis. Prophylactic e provided as per length of time prescribed | | | | | |
| | AS EVIDENCEI Based on record 1 of 3 employee | JLE WAS NOT MET D BY: review and interview for files reviewed (Direct ne facility failed to ensure | | | | | |

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| | of Correction identification number: 15G652 | (X2) MULTIPLE CC A. BUILDING B. WING | 00 | | LETED L/2013 |
|--------------------------|--|--|--|-----------|----------------------------|
| | NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | ADDRESS, CITY, STATE, ZIP (SEPH ST ISBURG, IN 47240 | CODE | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| | an annual Mantoux (5TU, PPD) tuberculosis screening was conducted. | | | | |
| | Findings include: | | | | |
| | A review of the facility's employee files was conducted on 1/8/13 at 1:08 PM. Direct Care Staff #3 had a negative Mantoux on 8/22/11. There was no documentation Direct Care Staff #3 had a Mantoux conducted since 8/22/11. An interview was conducted with the Administrative Staff (AS) #1 on 1/8/13 at 1:44 PM. AS #1 indicated the staff should have an annual Mantoux. 9-3-3(e) | | | | |

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